

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 09/22/04.

The IRO reviewed office visits, electrical stimulation, DME, manual therapy, neuromuscular re-education, and therapeutic exercises that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

The IRO reviewer established that all disputed services **were** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, electrical stimulation, DME, manual therapy, neuromuscular re-education, and therapeutic exercises.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On November 16, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 99212 for date of service 12/01/03 denied as "K, 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service." Per Section 408.023 of the Texas Labor Code and review of the ADL,

Brett L. Garner, D.C., dba Pain & Recovery Clinics of Houston is on the Approved Doctors List. The Medicare Fee Schedule times 125% lists the reimbursable amount to be \$46.41; however, the requestor billed \$29.74. Therefore, reimbursement in the amount of \$29.74 is recommended.

- CPT Code 97032 for date of service 12/01/03 denied as "K, 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service." Per Section 408.023 of the Texas Labor Code and review of the ADL, Brett L. Garner, D.C., dba Pain & Recovery Clinics of Houston is on the Approved Doctors List. Therefore, reimbursement in the amount of \$20.68 is recommended.
- HCPCS Code E1399 for date of service 12/01/03 denied as "K, 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service." Per Section 408.023 of the Texas Labor Code and review of the ADL, Brett L. Garner, D.C., dba Pain & Recovery Clinics of Houston is on the Approved Doctors List. Therefore, per Rule 134.202(c)(6) reimbursement is recommended and the carrier shall assign a relative value.
- CPT Code 97140 for date of service 12/01/03 denied as "K, 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service." Per Section 408.023 of the Texas Labor Code and review of the ADL, Brett L. Garner, D.C., dba Pain & Recovery Clinics of Houston is on the Approved Doctors List. Therefore, reimbursement in the amount of \$33.90 is recommended.
- CPT Code 97110 for date of service 12/01/03 denied as "K, 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service." Per Section 408.023 of the Texas Labor Code and review of the ADL, Brett L. Garner, D.C., dba Pain & Recovery Clinics of Houston is on the Approved Doctors List; however, recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting

- that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.
- CPT Code 97112 for date of service 12/01/03 denied as "K, 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service." Per Section 408.023 of the Texas Labor Code and review of the ADL, Brett L. Garner, D.C., dba Pain & Recovery Clinics of Houston is on the Approved Doctors List. Therefore, reimbursement in the amount of \$36.69 is recommended.

This Decision is hereby issued this 28th day January 2005.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees as follows:

- in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c)(6)
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 11/24/03 through 02/19/04 as outlined above in this dispute.

This Order is hereby issued this 29th day of November 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/mf

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-0323-01
Name of Patient:	
Name of URA/Payer:	Bose Consulting, LLC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Brett Garner, DC

November 9, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All

available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available documentation received and included for review consists of extensive records including initial report and subsequent treatment notes from Dr. Garner (DC), cervical and lumbar spine MRI's medical reports by Ray Esparza, M.D, Amil Soliz, MD, Andrew McKay, MD, John Adams, M.D; Guy Fogal MD, José Guerra-Paz.

___ was injured while moving some book cases with an associate while working for Sam's Club on _____. He attempted to work the following week, however due to increased pain levels he was referred to a company physician at Concentra where he was given pain medication and x-rayed, with apparently the institution of some physical therapy. He then presented on 9/18/03 to a chiropractor, Dr. Garner, whose initial assessment was of cervical discopathy with radiculitis, cervical and lumbar sprain/strain, rotator cuff tendonopathy and impingement syndrome. A conservative treatment régime was initiated consisting of exercises, neuromuscular reeducation, manual

therapy and electrical muscle stimulation under the direction of a physical therapist. This therapeutic régime failed to provide any dramatic improvement in the patient's condition and so MRI of the cervical spine was obtained on 10/10/03. This demonstrated diffuse herniation at C5/C6 and a left paracentral disc herniation at C6/C7. MRI on 12/19/03 demonstrated diffuse herniation at the L3/L4 level with disc desiccation. Patient was then referred for pain management consult to Dr. McKay, who recommended a series of three cervical ESI's, the first of which was performed on 11/19/03. On 12/30/03 lumbar ESI's were recommended in this was first performed on 1/14/04. The final ESI was performed on 3/2/04.

Eckard diagnostic studies were performed on 1/8/04 (Meyer Proler, M.D). This determined an abnormal study consistent with acute cervical cervical radiculopathy affecting the left C6 nerve root along with mild lumbar radiculopathy affecting the left L5 nerve root.

FCE performed on 1/9/04 showed a significant amount of self-limiting pain behavior with inconsistency and a work level demonstrated a sedentary-light PDL.

The patient was seen for RME purposes on 1/12/04 by David Vanderweide, MD. His opinion was that clinical findings were inconsistent and invalid. He did not recommend any further physical therapy or pain management. He recommended returning to work in a restricted manner, sedentary-light work level.

Through this time frame, the patient was seen for total of 21 visits. Some subjective reports of improvement by the patient were confirmed, but with continuing functional deficit.

REQUESTED SERVICE(S)

Medical necessity of office visits 99212, manual therapy 97140, therapeutic exercises 97110, electrical stimulation, neuromuscular reeducation, 97112 DME (E1399). Dates of service 11/24/03-2/19/04.

DECISION

Approved. There is establishment of medical necessity for all disputed services.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The patient sustained injuries to the cervical and lumbar spine areas, with some question as to the right shoulder. It is clear through agreement by all attending physicians that this was a difficult patient to manage, with chronic pain tendencies exhibited along with inconsistency/invalid effort and motivation. It is important to realize that this must not always be considered "malingering" / secondary gain. This behavior can be a fairly significant complicating factor/barrier to recovery. There were some equivocal objective findings on MRI. A period of conservative care was instituted with poor response, with appropriate referral for second opinion following a lack of improvement. The patient demonstrated mixed functional gains along with a reduced pain level during the period of time in dispute. Referral for the next stage of intervention in the form of ESI's was recommended in conjunction with continuing active therapy. There was some indication in the records that the patient did respond to this intervention. Concurrent rehabilitation with ESI's is accepted protocol.

In conclusion, appropriate treatment interventions were implemented, albeit with equivocal effects. Considering the patient's chronic pain tendencies, the care rendered satisfied the above standard of medical necessity.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

Spine 2002, volume 1, 28. Page 11-16.